Medicare

for Railroad Workers and Their Families

U.S. Railroad Retirement Board Mission Statement

The Railroad Retirement Board's mission is to administer retirement/survivor and unemployment/sickness insurance benefit programs for railroad workers and their families under the Railroad Retirement Act and the Railroad Unemployment Insurance Act. These programs provide income protection during old age and in the event of disability, death or temporary unemployment and sickness. The Railroad Retirement Board also administers aspects of the Medicare program and has administrative responsibilities under the Social Security Act and the Internal Revenue Code.

In carrying out its mission, the Railroad Retirement Board will pay benefits to the right people, in the right amounts, in a timely manner, and safeguard our customers' trust funds. The Railroad Retirement Board will treat every person who comes into contact with the agency with courtesy and concern, and respond to all inquiries promptly, accurately and clearly.

Why you should read this booklet . . . Sooner or later, nearly everyone will be affected by Medicare, the nation's major Federal health insurance program. In fact, if you pay taxes you're already affected by Medicare because a portion of your taxes goes to finance part of the Medicare program.

Even though you're paying into the Medicare program during your working years, and will probably rely on its services in the future, you may not be aware of what benefits the program offers--and what it doesn't offer. The basic information in this booklet will give you an overview of the Medicare program.

What's Inside . . .

This booklet is issued for the purpose of general information. Certain limitations, exceptions and special cases are not covered.

WHAT IS MEDICARE?

Medicare is our country's health insurance program for people age 65 or older, certain people with disabilities who are under age 65, and people of any age who have permanent kidney failure. It provides basic protection against the cost of health care, but it doesn't cover all medical expenses or the cost of most long-term care.

Medicare is financed by a portion of railroad retirement tier I and social security payroll taxes paid by employees and employers. It is also financed in part by monthly premiums paid by enrollees.

The Centers for Medicare & Medicaid Services is the agency in charge of the Medicare program. But we, the staff of the Railroad Retirement Board, help you enroll in the program and give you general Medicare information.

Medicare Has Two Parts

- **Hospital Insurance** (also called Medicare "Part A"), which helps pay for hospital and skilled nursing facility care, home health care, and hospice care; and

- **Medical Insurance** (also called Medicare "Part B"), which helps pay for doctors, outpatient hospital care, and other medical services.

A Word About Medicaid

You may think that Medicaid and Medicare are two different names for the same program. Actually, they are two different programs. Medicaid is a State-run program designed primarily to help those with low income and little or no resources. The Federal Government helps pay for Medicaid, but each State has its own rules about who is eligible and what is covered under Medicaid. Some people qualify for both Medicare and Medicaid.

For more information about the Medicaid program, contact your State medical assistance office. You can get the telephone number for your State medical assistance office by calling the Medicare toll-free number, 1-800-MEDICARE (1-800-633-4227), TTY/TDD 1-877-486-2048 for the hearing and/or speech impaired. You can also go to www.medicare.gov on the Internet, click on "Helpful Contacts," and search for your State medical assistance office under "Other Health Insurance Programs."

WHO CAN GET MEDICARE?

Hospital Insurance (Part A)

If you are age 65 or older. Most people age 65 or older who are citizens or permanent residents of the United States are eligible for Medicare hospital insurance (Part A) without paying a monthly premium based on their own--or their spouse's--employment. You are eligible at age 65 if you receive or are eligible to receive railroad retirement or social security benefits.

If you are under age 65. Before age 65, you are eligible for premium-free Medicare hospital insurance if you have been entitled to monthly benefits based on **a total disability** for at least 24 months. (Special rules apply for disabled individuals diagnosed with Amyotrophic Lateral Sclerosis.)

Eligibility for family members. Under certain conditions, your spouse, divorced spouse, surviving divorced spouse, widow or widower, or a dependent parent may be eligible for hospital insurance when she or he turns age 65, based on your work record.

Also, disabled widows and widowers under age 65, disabled surviving divorced spouses under age 65, and disabled children may be eligible for Medicare, usually after a 24-month qualifying period.

If you have permanent kidney failure. If you have permanent kidney failure, you are eligible for free Medicare hospital insurance at any age. This is true if you receive maintenance dialysis or a kidney transplant and you are eligible for or are receiving monthly benefits under the railroad retirement or social security system.

In addition, your spouse, divorced spouse or child may be eligible, based on your work record, if she or he has permanent kidney failure and receives maintenance dialysis or a kidney transplant.

Medical Insurance (Part B)

Anyone who is eligible for free Medicare hospital insurance (Part A) can enroll in Medicare medical insurance (Part B) by paying a monthly premium. (The basic monthly premium in 2003 is $58.70.)

MEDICARE SAVINGS PROGRAMS

"Medicare Savings Programs" can help people with Medicare save money each year. The programs, which are run by the States, are for people with limited income and resources. The programs pay some or all of Medicare's premiums. Some programs may also pay Medicare deductibles and coinsurance.

To qualify, you must have Medicare Part A (hospital insurance), a limited income, and your assets, such as bank accounts, stocks and bonds, must not be more than $4,000 for a single person or $6,000 for a couple.

If you are not sure if you have Part A, look on your red, white, and blue Medicare card, which will show "Part A (hospital insurance)" on the lower left corner of the card. You can also call your local Railroad Retirement Board office. Get the telephone number of your local office by visiting the Board's Web site at www.rrb.gov or by calling our automated toll-free Help Line at 1-800-808-0772.

Only your State can decide if you qualify under a Medicare savings program. To find out if you qualify, contact your State medical assistance office, as described on page 3 of this leaflet. Individual States may have more generous income and/or resource requirements. Therefore, it is very important to call your State medical assistance office and ask for information, if you think you might qualify for a Medicare savings program.

More information about Medicare savings programs is in the publication, *Don't Miss Out on Your Turn for Medicare Savings!* To get a copy, call the Medicare toll-free number 1-800-MEDICARE (1-800-633-4227),

TTY/TDD 1-877-486-2048, or visit www.medicare.gov on the Internet and click on "Publications."

SIGNING UP FOR MEDICARE

If you're already getting railroad retirement or social security benefits, you will be contacted a few months before you become eligible for Medicare and given the information you need. You will automatically be enrolled in Medicare Parts A and B. However, because you must pay a premium for Part B coverage, you have the option of turning it down.

If you aren't already getting benefits, you should contact your local Board office about 3 months before your 65th birthday to sign up for Medicare. You can sign up for Medicare even if you don't plan to retire at age 65.

You should also contact us about applying for Medicare if:

- you're a disabled widow or widower between age 50 and age 65 but haven't applied for disability benefits because you're already getting another kind of benefit;

- you had Medicare medical insurance in the past but dropped the coverage;

- you turned down Medicare medical insurance when you became entitled to hospital insurance; or

- you, your spouse, or your dependent child has permanent kidney failure. (Contact a social security office in these cases to see if you are eligible.)

Initial Enrollment Period

When you first become eligible for hospital insurance (Part A), you have a 7-month period to sign up for medical insurance (Part B). This is called your "initial enrollment period." If you are eligible at age 65, your initial enrollment period begins 3 months before your 65th birthday, includes the month you turn age 65, and ends 3 months after that birthday. If you are eligible for Medicare based on disability or permanent kidney failure, your initial enrollment period depends on the date your disability or treatment began.

If you already receive retirement or disability benefits, you will be automatically enrolled in Part B when you become entitled to Part A. However, because you must pay a premium for Part B coverage, you have the option of paying for the coverage or turning it down.

When does my enrollment in Part B become effective? If you accept the automatic enrollment in Medicare Part B, or if you enroll in Medicare Part B during the first 3 months of your initial enrollment period, your medical

insurance protection will start with the month you are first eligible. If you enroll during the last 4 months, your protection will start from 1 to 3 months after you enroll.

The chart on page 10 shows when your Medicare Part B becomes effective.

General Enrollment Period

If you don't enroll in Medicare Part B during your initial enrollment period, you have another chance each year to sign up during a "general enrollment period" from January 1 through March 31. Your coverage begins the following July. However, your monthly premium increases 10 percent for each 12-month period you were eligible but didn't enroll. You may be able to request premium surcharge relief if you were covered by an employer group health plan.

WHEN MEDICARE PART B BECOMES EFFECTIVE

If you enroll in this month of your initial enrollment period:	*Then your Medicare Part B coverage starts:*
1	the month you become eligible for Medicare
2	the month you become eligible for Medicare
3	the month you become eligible for Medicare
4	1 month after enrollment
5	2 months after enrollment
6	3 months after enrollment
7	3 months after enrollment

A Word About Your Medicare Card

Once you are enrolled in Medicare, you will receive a red, white, and blue Medicare card showing whether you have Part A, Part B, or both. Keep your card in a safe place so you'll have it when you need it. If your card is ever lost or stolen, you can apply for a replacement card on the Internet at www.rrb.gov or by calling our automated Help Line at toll-free 1-800-808-0772.

Special Enrollment Period for People Who Have Employer Group Health Plans

If you are age 65 or older and are covered under a group health plan either from your own or your spouse's current employment, you may have a "special enrollment period" in which to sign up for Medicare Part B. This means that you may delay enrolling in Medicare Part B without having to wait for a general enrollment period or pay the 10-percent premium surcharge for late enrollment. The rules allow you to:

- enroll in Medicare Part B any time while you are covered under the group health plan; or

- enroll in Medicare Part B during the 8-month period that begins with the first full month after your group health coverage ends, or your employment ends--whichever comes first.

If you enroll in Part B while covered by an employer-provided group health plan or during the first full month when you are not covered by that plan, you have the option to have your coverage begin the first day of the month you enroll or to delay coverage until the first day of any of the following 3 months.

If you enroll during any of the 7 remaining months of the 8-month period, your coverage will begin the month after you enroll.

Special enrollment period rules do not apply if employment or employer-provided group health plan coverage ends during your initial enrollment period.

If you do not enroll by the end of the 8-month period, you'll have to wait until the next general enrollment period, which begins January 1 of the next year.

People who receive disability benefits and are covered under a group health plan from either their own or a family member's current employment also have special enrollment period and premium rights that are similar to those for workers age 65 or older.

Special Enrollment Period and Medigap. When you make your decision as to when to enroll in Part B, you must consider how this will affect your eligibility for other health insurance policies you may wish to purchase to supplement your Medicare coverage. Such supplemental policies are known as "Medigap" insurance. (See pages 22-23 for a complete explanation of Medigap insurance.)

When you enroll in Medicare Part B at or after age 65, you trigger a one-time "Medigap open enrollment period." If you enroll in Part B while you are covered under an employer-provided group health plan, you may not need a Medigap policy. The employer plan will be the primary payer, and your Medicare Part B will be the secondary payer. Later, however, when you are no longer covered by your employer-provided group health plan, you may need a Medigap policy, but may be unable to purchase one because your Medigap open enrollment period will have expired.

If, on the other hand, you delay Part B enrollment until your employer-provided group health plan coverage is about to stop, you will be able to use your open enrollment period

to your best advantage. During open enrollment, you may purchase any Medigap plan from any company at its most favorable price for your age group. You can purchase policies that cover outpatient prescription drugs, which generally are not available outside of the open enrollment period unless you are healthy.

WHAT MEDICARE COVERS

The two parts of Medicare are designed to help pay for different kinds of health care costs. Some kinds of health care aren't covered by Medicare at all.

Hospital Insurance (Part A)

Medicare hospital insurance can help pay for inpatient care in a hospital or skilled nursing facility following a hospital stay, home health care, and hospice care. Except for home health care, each is subject to a benefit period, which measures your use of services covered by Medicare Part A.

A benefit period starts the day you enter a hospital. It ends when you have been out of the hospital or other facility primarily providing skilled care for 60 days in a row. If you remain in such a facility (other than a hospital), a benefit period ends when you have not received

any skilled care there for 60 days in a row. There is no limit to the number of benefit periods for hospital and skilled nursing facility care. But special limits do apply to hospice care.

Inpatient hospital care. If you need inpatient care, hospital insurance helps pay for up to 90 days in any Medicare-participating hospital during each benefit period. In 2003, hospital insurance pays for all covered services for the first 60 days, **except for the first $840**. For days 61 through 90, hospital insurance pays for all covered services **except for $210 a day**.

If you are out of the hospital for at least 60 days in a row, and then go back in, a new benefit period begins--your 90 days of coverage starts all over again, and you pay another deductible.

What if you need more than 90 days of inpatient care during any benefit period? You can use some or all of your "reserve days." Reserve days are an extra 60 hospital days you can use if your illness keeps you in the hospital for more than 90 days. You have **only** 60 reserve days in your lifetime, and you decide when you want to use them. For each reserve day you use, hospital

insurance pays for all covered services **except for $420 a day in 2003.**

Skilled nursing facility care. If you need inpatient skilled nursing or rehabilitation services after a hospital stay and you meet certain other conditions, hospital insurance helps pay for up to 100 days in a Medicare-participating skilled nursing facility in each benefit period.

Hospital insurance pays for all covered services for the first 20 days. For the next 80 days, it pays for all covered services **except for $105 a day in 2003.**

Home health care. If your health problems cause you to stay at home and you meet certain other conditions, Medicare can pay the full approved cost of home health visits from a Medicare-participating home health agency. There is no limit to the number of covered visits you can have.

If you need one or more of the services Medicare pays for, then hospital insurance also covers part-time or intermittent services of home health aides, occupational and physical therapy, medical social services, and medical supplies and equipment. A 20-percent copayment applies to covered durable medical equipment (e.g., wheelchairs and hospital beds).

Hospice care. A hospice program provides pain relief and other support services for terminally-ill people. Medicare hospital insurance can help pay for hospice care for terminally-ill beneficiaries if the care is provided by a Medicare-certified hospice and certain other conditions are met.

You can get hospice care as long as your doctor certifies that you are terminally ill and probably have less than 6 months to live. Even if you live longer than 6 months, you can get hospice care as long as your doctor recertifies that you are terminally ill.

Hospice care is given in periods of care. As a hospice patient, you can get hospice care for two 90-day periods followed by an unlimited number of 60-day periods. At the start of each period of care, your doctor must certify that you are terminally ill in order for you to continue getting hospice care. A period of care starts the day you begin to get hospice care. It ends when your 90- or 60-day period is up. If your doctor recertifies that you are terminally ill, your care continues through another period of care.

Medical Insurance (Part B)

Medicare medical insurance helps pay for doctors' services and many other medical services and supplies that are not

covered by the hospital insurance part of Medicare. Each year, you must pay an annual medical insurance deductible amount before Medicare begins paying. In 2003, the annual deductible is $100. After you have paid the deductible, Medicare will generally pay 80 percent of the approved charges for covered services during the rest of the year. You are responsible for paying the remaining 20 percent of the cost. This is called coinsurance.

Medical Insurance (Part B) Covers:

- inpatient medical care;
- outpatient hospital care;
- inpatient and outpatient medical supplies;
- ambulance services;
- X-rays;
- laboratory tests;
- durable medical equipment such as wheelchairs and home orthopedic beds;
- services of certain specially-qualified professionals who are not doctors;
- physical and occupational therapy;
- speech therapy;

- partial hospitalization for psychiatric medical attention;
- home attention if you don't have Part A;
- blood;
- yearly mammograms;
- Pap smears;
- pelvic and breast examinations;
- diabetes glucose monitoring and education;
- colorectal cancer screening;
- bone mass measurements; and
- flu and pneumococcal pneumonia shots.

WHAT MEDICARE DOES NOT COVER

Medicare provides basic health care coverage, but it doesn't pay all of your medical expenses. Here are examples of what Medicare **does not** pay for:

- "custodial care." (This is care that **could** be given safely and reasonably by a person who is not medically skilled, and that is given mainly to help the patient with daily living. Examples include help with walking, bathing, and dressing. Even if you are in a participating hospital

or skilled nursing facility, or you are getting care from a participating home health agency, Medicare **does not** cover the cost of care if it is mainly custodial.)

- most nursing home care;
- dental care and dentures;
- routine checkups and the tests directly related to these checkups (some screening, Pap smears, and mammograms are covered);
- most immunization shots (some flu and pneumonia shots are covered);
- most prescription drugs;
- routine foot care;
- tests for, and the cost of, eyeglasses or hearing aids;
- personal comfort items, such as a phone or TV in your hospital room;
- long-term care; and
- services outside the United States. (Hospital services in Canada are covered by Medicare. Medical services in Canada and hospital and medical services in Mexico may be covered but only under very limited conditions.)

You can get more detailed information about what is covered under Medicare Part A and Part B from the publication, *Your Medicare Benefits.* To get a copy, call the Medicare toll-free number 1-800-633-4227 or go to www.medicare.gov on the Internet and click on "Publications."

OPTIONS FOR RECEIVING HEALTH CARE SERVICES

Medicare beneficiaries may have choices for receiving health care services. What you choose is a personal decision based on your particular health needs. However, you should consider all of the options carefully and decide what is best for you. A well-informed and well-thought-out decision could save you a lot of money and inconvenience.

Original Medicare Plan

Under the Original Medicare Plan, you can visit the hospital, doctor, or health care provider of your choice who accepts Medicare patients. Medicare pays a set percentage of the expenses, and you are responsible for certain deductibles and coinsurance payments--the portion of the bill Medicare does not pay.

Palmetto GBA, a subsidiary of Blue Cross and Blue Shield of South Carolina, processes medical insurance (Part B) claims for railroad retirement beneficiaries in the Original Medicare Plan. If you are in the Original Medicare Plan, your hospital, doctor, or other health care provider should submit Part B claims directly to:

Palmetto GBA
Railroad Medicare Part B Office
P.O. Box 10066
Augusta, GA 30999-0001

If you have questions about Part B claims under the Original Medicare Plan, write to Palmetto GBA at the above address; telephone them toll-free at 1-800-833-4455, (TTY/TDD: 1-877-566-3572); or go to www.palmettogba.com on the Internet, click on "Railroad Medicare" under "Beneficiaries," and select "Contact Us."

Medigap Insurance

Medicare provides basic health care coverage, but it can't pay all of your medical expenses. For this reason, many private insurance companies sell insurance to fill in the gaps in Medicare coverage. This kind of insurance is called "Medigap" for short. There are 10 standard Medigap policies, and each offers a different combination of benefits.

Medigap policies pay most, if not all, Medicare coinsurance amounts and may provide for Medicare deductibles. Some of the 10 standard policies pay for services not covered by Medicare, such as outpatient prescription drugs and preventive screening.

You may want to consider a Medicare SELECT policy, which is a Medigap policy in which you are required to use certain hospitals and doctors. The SELECT policies generally have lower premiums than other Medigap policies.

When you first enroll in Medicare Part B at age 65 or older, you have a 6-month "Medigap open enrollment period." During that time, you have a right to buy the Medigap policy of your choice regardless of any health problems you may have. The company cannot refuse you a policy or charge you more than other open enrollment applicants.

You can get more detailed information about Medigap policies from the publications *Medigap Policies* or *Guide to Health Insurance for People with Medicare*. To get a copy, call the Medicare toll-free number 1-800-633-4227 or go to www.medicare.gov on the Internet and click on "Publications."

Medicare Managed Care Plans

Another available option, which may save you money and provide additional benefits, is joining a managed care plan. The most common plans are health maintenance organizations (HMOs).

Medicare Managed Care Plans that have contracts with the Medicare program must provide all hospital and medical benefits covered by Medicare. However, usually you must obtain services from your Managed Care Plan's network of health care providers (doctors, hospitals, skilled nursing facilities, for example). In most cases, neither the Managed Care Plan nor Medicare will pay for services not authorized by your Managed Care Plan (except emergency services or services urgently required while you are out of the Managed Care Plan's service area).

Each Managed Care Plan that has a contract with Medicare gets paid every month for services it provides to you. As a Medicare Managed Care Plan member, you will have to enroll in Medicare Part B. You may also have to pay some or all of your Part B monthly premium.

Many Managed Care Plans that have contracts with Medicare also provide

benefits beyond those Medicare pays for. These include preventive care, prescription drugs, dental care, hearing aids, and eyeglasses. The benefits may vary by Managed Care Plan and you'll need to read the individual descriptions to determine which benefits are offered by each.

Private Fee-For-Service Plan

This is a health care choice in some areas of the country. A Private Fee-for-Service Plan is a Medicare health plan offered by a private insurance company. It is not the same as the Original Medicare Plan, which is offered by the Federal government. In a Private Fee-for-Service Plan, Medicare pays a set amount of money every month to the private company. The private company provides health care coverage to people with Medicare on a pay-per-visit arrangement. The insurance company, rather than the Medicare program, decides how much you pay for the services you get. For more information about these plans, call the Medicare toll-free number 1-800-633-4227 or go to www.medicare.gov on the Internet and click on "Publications," then click on "Your Guide to Private Fee-for-Service Plans."

More Information About Other Plans

You can get more information about your health care options from the following publications:

- *Medicare & You*.--This general guide is mailed to Medicare beneficiary households each fall and to new Medicare beneficiaries when they become eligible for the coverage. It describes the benefits, costs, and health service options available.

- *Guide to Health Insurance for People with Medicare*.--A guide to how other health insurance plans supplement Medicare and some shopping hints for people looking at those plans.

To get a copy of these, or any other, publications, call the Medicare toll-free number 1-800-633-4227 or go to www.medicare.gov on the Internet and click on "Publications."

Some publications may instruct you to call or visit an office of the Social Security Administration for assistance. Railroad retirement beneficiaries should contact the nearest Railroad Retirement Board office.

How Do I Find Out About The Specific Plans Available In My Area?

You can get the names of the plans in your area by calling the Medicare toll-free number 1-800-633-4227 and asking for a free, up-to-date list of all the plans offered where you live. Or you can go to www.medicare.gov on the Internet and click on "Medicare Health Plan Compare."

You can also get a summary of your health care options and what each plan in your area offers by going to www.medicare.gov and clicking on "Medicare Personal Plan Finder."

If you need to talk to someone about deciding which plan is right for you, you can call your State Health Insurance Assistance Program and a volunteer counselor will help you. You can get the telephone number of the program in your State from the Medicare toll-free number. Or you can go to www.medicare.gov, click on "Helpful Contacts" and then "General Medicare Information."

IF YOU HAVE OTHER HEALTH INSURANCE

Medicare hospital insurance is premium-free for almost everyone, but

you generally pay a monthly premium for medical insurance. If you already have other health insurance when you become eligible for Medicare, is it worth the monthly premium cost to sign up for Medicare medical insurance?

The answer varies with the individual, and the kind of other health insurance. Although we can't give you "yes" or "no" answers, we can offer a few tips that may be helpful when you make your decision.

If You Have A Private Insurance Plan

Get in touch with your insurance agent to see how your private plan fits with Medicare medical insurance. This is especially important if you have family members who are covered under the same policy. And remember, just as Medicare doesn't cover all health services, most private plans don't either. In planning your health insurance coverage, keep in mind that most nursing home care is not covered by Medicare or private health insurance policies. One important word of caution: For your own protection, **don't cancel any health insurance you now have until your Medicare coverage actually begins**.

If You Have Health Insurance From An Employer-Provided Group Health Plan

Group health plans of employers with 20 or more employees are required by law to offer workers who are age 65 (or older) the same health benefits that are provided to younger employees. They must also offer the spouses who are age 65 (or older)--of workers of any age--the same health benefits given younger spouses.

If you are age 65 or older and have current employment--or you are age 65 or older and are the spouse of a person who has current employment--and you accept the employer's health insurance plan, Medicare will be the secondary payer. This means the employer plan pays first on your hospital and medical bills. If the employer plan does not pay all of your expenses, Medicare may pay secondary benefits.

If you reject the employer's health plan, Medicare will be the primary health insurance payer. The employer is **not** allowed to offer you Medicare supplemental coverage if you reject his or her health plan.

If you are under 65 and disabled, and you are currently employed or are the family member of a person who has current employment and you have health coverage under a "large group health plan," Medicare will be the secondary payer. A large group health plan covers employees of an employer or group of employers of which at least one employer has 100 or more workers.

If you are entitled to Medicare because of permanent kidney failure and you have employer-provided group health coverage, Medicare will be the secondary payer for the first 30 months of your Medicare Part A eligibility or entitlement. At the end of the 30-month period, Medicare becomes your primary payer.

If You Have Health Care Protection From Other Plans

If you have health care protection from the Indian Health Service, Department of Veterans Affairs or a State medical assistance program, contact the people in those offices to help you decide whether it is to your advantage to have Medicare medical insurance.

Need More Information?

We've covered a number of difficult rules. If you aren't sure if any apply to you, contact the nearest Railroad Retirement Board office for help. You can also use our automated toll-free number and Web site or Medicare's information sources as described on the back cover of this leaflet.

NONDISCRIMINATION ON THE BASIS OF DISABILITY

Under Section 504 of the Rehabilitation Act of 1973 and Railroad Retirement Board regulations, no qualified person may be discriminated against on the basis of disability. The Board's programs and activities must be accessible to all qualified applicants and beneficiaries, including those with impaired vision and/or hearing. Individuals with disabilities needing assistance (including auxiliary aids or program information in accessible formats) should contact the nearest Board office. Complaints of alleged discrimination by the Board on the basis of disability must be filed within 90 days in writing with the Director of Administration, Railroad Retirement Board, 844 North Rush Street, Chicago, Illinois 60611-2092. Questions about individual rights under this regulation may be directed to the Board's Director of Equal Opportunity at the above address.

FRAUD AND ABUSE HOT LINE

Call the toll-free Hot Line if you have reason to believe that someone is receiving railroad retirement or unemployment-sickness benefits to which he or she is not entitled; that a person responsible for the financial affairs of a minor or other benefit recipients who are unable to manage their own affairs is misappropriating benefits; or that a doctor, hospital or other provider of health care services is performing unnecessary or inappropriate services or billing Medicare for services not provided.

You may also use the Hot Line to report any suspected misconduct by a Railroad Retirement Board employee. The Hot Line has been installed by the Railroad Retirement Board's Inspector General to receive any evidence of such fraud or abuse of the Board's benefit programs. The toll-free Hot Line number nationwide is 1-800-772-4258. You may send your complaints in writing to RRB, OIG, Hot Line Officer, 844 North Rush Street, Chicago, Illinois 60611-2092 or via e-mail at hotline@oig.rrb.gov. Please do not call or write the Inspector General's Hot Line with questions about eligibility requirements, delayed payments, or similar problems. Such matters should be directed to the nearest Railroad Retirement Board office.

Railroad Retirement Board Help Line and Web Site

1-800-808-0772
www.rrb.gov

The Railroad Retirement Board's toll-free automated Help Line is available at 1-800-808-0772. Retirees can call the Help Line to request a letter showing their current monthly benefit rate. Railroad Medicare beneficiaries can request a replacement Medicare card. Active railroad employees can use the Help Line to request a statement of their creditable railroad service and compensation and information on unemployment-sickness claims is available. Callers can also find the address and telephone number for the field office serving their area and listen to special announcements about the benefit programs administered by the agency. *The Help Line is available 24 hours a day, 7 days a week.*

Most of these services are also available on the Board's Web site at www.rrb.gov. In addition, the Web site has information about benefit requirements, customer service standards and other topics of interest. Many Board publications are available for downloading.

Medicare Toll-Free Number and Web Site

1-800-MEDICARE (1-800-633-4227)
TTY/TDD 1-877-486-2048
www.medicare.gov

Call the Medicare toll-free number or look on the Web site to get help with your Medicare questions.

U.S. Railroad Retirement Board
844 North Rush Street
Chicago, Illinois 60611-2092

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